**Application for CCG Funding**

Date:

*Please ensure the Patient’s name is represented by their initials only*

|  |  |  |
| --- | --- | --- |
| **PATIENT INFORMATION** | | |
| **Type of request:** | **NEW CONTINUED ADDITIONAL** | |
| **Rio Number:** |  | |
| **Year of Birth:** |  | |
| **Age:** |  | |
| **GP Name & Location:** |  | |
| Does the person have capacity to make their own decision relating to this service?  If so has written consent been obtained? | YES / NO  YES / NO | |
| If not has a formal MCA been recorded and how have you arrived at this decision? (details of best interest decision, role of advocate & IMCA) |  | |
| Is the individual subject to S117 aftercare?  If yes, please confirm Section & Date: | YES / NO  Section: Date: | |
| Mental Health Diagnosis: |  | |
| Presenting Physical issues: |  | |
| Presenting Mental Health issues: |  | |
| **PROPOSER**  *(Please identify the team and details of the staff member submitting this funding application).* | | |
| Team: | |  |
| Person submitting application: | |  |
| Position: | |  |
| Date: | |  |
| **CURRENT CIRCUMSTANCES**  *(Please explain in full)* | | |
| What are the current circumstances of the person? | |  |
| Is the individual in receipt of any existing care plan or package of care?  If so, please give details: | |  |
| Have all local options been provided / attempted?  **Please give full details of relevant/recent treatment and interventions provided locally (to date) and their outcomes.** | |  |
| **RISKS** | | |
|  | | |
| **PROPOSED SUPPORT ARRANGEMENTS** | | |
| **SUPPORT** - What is being requested? (details of service/support). | |  |
| **PLAN** - Support Plan (day of week - am/pm/ night time etc.) with crisis management (support in place/what will happen if support is not available?) | |  |
| **WHY** - Reason for request? | |  |
| **OPTIONS** - What other services have been considered? | |  |
| **PROVIDERS** - Providers considered, preferred provider, reasons and Care Funding Calculator comparison made | |  |
| **INVOLVEMENT** - How has the individual/family been involved in this decision? (include best interest decision making or use of advocate & preferences noted). | |  |
| **OUTCOMES** - What outcomes will this service/ support package deliver to the individual? (include over what period of time and the review process) | |  |
| **DIVERSITY** - Have the individual’s cultural needs been considered?  If so, how they will be met by proposed intervention/ provider? | |  |
| **SAFETY** - CQC report & safeguarding checks completed? | |  |
| **FINANCIAL INFORMATION** | | |
| Cost details:  Current and/or proposed (per week) | |  |
| Is this a Joint or Sole application to Health? If Joint please confirm **%** split proposed:  Has LA funding application been submitted / approved? | | YES / NO |
| **Clinical Information** | | |
| Is this application supported by the Clinical team involved in the patients care? Care Co-ordinator/Clinical Lead, Consultant Psychiatrist | | YES / NO |

Signed: Date:

Care Co-ordinator /

Person completing form: Date:

Consultant Psychiatrist: Date:

Locality Manager: Date:

East Panel

Representative: Date: